U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 March 2004

CASE NO.: 2001-BLA-1142

In the Matter of:

JACK BREWER,
Claimant

v.

K.T.K. MINING AND CONSTRUCTION COMPANY, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Susan Vanzant, Esq.,
For the Claimant

Lois A. Kitts, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on October 26, 2000, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his first prior claim for benefits on November 3, 1992. (Director's Exhibit ("DX") 28-63). The claim was denied because the evidence failed to establish Mr. Brewer suffered from coal workers' pneumoconiosis. (DX 28-63). On August 30, 1994, Administrative Law Judge Joel Williams issued a Decision and Order denying benefits.

The claimant filed his current claim for benefits on October 26, 2000. (DX 1). On March 16, 2001, the Department of Labor denied the claim because the evidence failed to establish the elements of entitlement that Mr. Brewer was totally disabled due to pneumoconiosis. The Department of Labor also found that the evidence failed to support a finding of a material change in condition. (DX 17). On March 27, 2001, the claimant requested a hearing before an administrative law judge. On August 22, 2001, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. I was assigned the case on May 31, 2002.

On September 25, 2003, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-2, Director's exhibits ("DX") 1-30, and Employer's exhibits ("EX") 1-6 were admitted into the record.

Employer submitted the following evidence after the hearing:

i. Dr. David M. Rosenberg's Curriculum Vitae;
ii. Medical report by Dr. David M. Rosenberg, dated November 4, 2003;
iii. Dr. Alex Poulos' Curriculum Vitae;
iv. X-ray interpretation by Dr. Alex Poulos, dated October 28, 2003;
v. Dr. Jerome Wiot's Curriculum Vitae; and
vi. X-ray interpretation by Dr. Jerome Wiot, dated October 13, 2003.

These exhibits are hereby admitted into the record and marked as Employer's Exhibits (EX) 7 through 12, respectively.

[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. *Glen Coal Co. v. Seals*, 147 F.3d 502, 1998 WL 329417, 21 B.L.R. 2-398 (6th Cir. 1998)(Although the miner was receiving treatment in Virginia, the injury resulted from his Kentucky Coal mine work which required analysis under Sixth Circuit law). *Seals*, n. 5. Mr. Brewer was last exposed to coal mine dust at K.T.K. Mining and Construction Company located in Kentucky. Thus, under *Glen Coal Co.*, Sixth Circuit law controls Mr. Brewer's claim for benefits.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a material change in the claimant's condition?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least ten years, as stipulated by the parties. (Hearing Transcript (TR) 6).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on October 26, 2000. (DX 1). The claim was timely filed.

C. Responsible Operator[2]

K.T.K. Mining and Construction Company, Inc. is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001, Part 725 of the Regulations). (TR 7).

D. Dependents[3]

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife Pauline Brewer. (DX 6; TR 8, 12).

E. Personal and Employment History

The claimant was born on November 22, 1939. (DX 1). He married Pauline Spaulding, on February 6, 1965. (DX 6). The Claimant's last position in the coal mines was that of a roof bolter. (DX 2). He last worked in the mines in 1991.

[2] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.
[3] See 20 C.F.R. §§ 725.204-725.211.

The claimant, as part of his duties, was required to pin top. (EX 5, p.16). Claimant had to pin bolts to hold up the roof structure of the mine. This position put him in the face of the mine.

Additionally, Claimant has never smoked or chewed tobacco.

II. Medical Evidence

I incorporate by reference the summary of evidence contained in Judge Williams' Decision and Order Denying Benefits. (DX 28-63). The following is a summary of the evidence submitted since the final denial of the prior claim.

A. Chest X-rays[4]

There were 29 readings of 10 X-rays, taken on October 28, 2003, February 3, 2003, February 17, 2001, December 5, 2000, July 17, 1993, December 1, 1992, May 27, 1992, May 16, 1992, April 1, 1992 and January 7, 1992. (DX 11, 12, 13, 15, 16, 22 and 26; CX 1; EX 8, 10 and 12). Three are positive, by three physicians, Drs. Pathak, Gaziano and Navani, who are B-readers.[5] Twenty-six are negative, by 12 physicians, Drs. Broudy, Dahhan, Eisner, Kim, Lieber, Poulos, Ranavaya, Rosenberg, Scott, Spitz, Wheeler and Wiot, all of whom are either B-readers, Board-certified in radiology, or both, with the exception of Drs. Broudy, Dahhan and Ranavaya.[6] A summary of the chest X-ray evidence is attached as Appendix A.

CT Scans

The record contains the results of one CT scan read by Board-Certified Radiologist Dr. Poulos (EX 9). It shows no evidence of coal workers' pneumoconiosis. (EX 8). Dr. Poulos stated:

> The examination reveals no evidence of small opacities noted in either lung that would be consistent with coal worker's pneumoconiosis. Mild centrilobular emphysematous changes are noted in both lower lobes. No areas of consolidation or regions of volume loss are noted. No pleural plaque formation is evident. No significant mediastinal adenopathy is identified.

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[4] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[5] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

[6] *Cranor v. Peabody Coal Co.,* 21 B.L.R.1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon*. 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's X-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on X-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation)."

(EX 8). A CAT scan falls into the "other means" category of 20 C.F.R. § 718.304(c) rather than being considered an X-ray under § 718.304(a). A CAT scan is "computed tomography scan or computer aided tomography scan. Computed tomography involves the recording of 'slices' of the body with an x-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, bringing them into sharp focus while deliberately blurring structures at other depths. *See,* THE BANTAM MEDICAL DICTIONARY, 96, 437 (Rev. Ed. 1990)." *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991). In *Consolidation Coal C. v. Director, OWCP [Stein]*, ___ F.3d ___, 22 B.L.R. 2-409, 2002 WL 1363785 (7th Cir. June 25, 2002), the Court rejected the employer's argument that a negative CT is conclusive evidence the miner does not have pneumoconiosis. The DOL has rejected such a view. Nor need a negative CT be given controlling weight because the statutory definition of "pneumoconiosis" encompasses a broader spectrum of diseases than those pathological conditions which can be detected by clinical test such as X-rays and CT scans.

B. Pulmonary Function Studies[7]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comp-rehension** **Cooper-ation**	**Qualify *** **Conform ****	**Dr.'s** **Impression**
Dr. Rosenberg 10/28/03 EX 8	63 69 in.	2.54	23	3.43	Yes	Good Good	No Yes	
Dr. Boustani 2/26/03 CX 2	63 72 in.	2.81	49	3.56	Yes		No Yes	Small airway obstruction. Mild decrease in FEV1 with no

[7] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function test are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comp-rehension** **Cooper-ation**	**Qualify *** **Conform ****	**Dr.'s** **Impression**
								improvement post bronchodilator. Diffusion capacity – normal. This study could be consistent with small airway obstructive lung disease with improvement post bronchodilators in small airways.
Dr. Boustani 2/26/03 CX 2 Post-bron	63 72 in.	2.71		3.25			No Yes	
Dr. Dahhan 2/17/01 DX 16	61 67 in.	2.53	52.39	3.33	Yes	Good Fair	No Yes	Spirometry showed invalid studies due to poor effort.
Dr. Dahhan 2/17/01 DX 16 Post-bron	61 67 in.	2.87	49.25	3.36	Yes	Good Fair	No Yes	MVV was invalid due to poor effort.
Dr. Ranavaya	61	1.31	23.5	3.33	Yes	Poor	Yes	Mr. Brewer made numerous

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comp-rehension** **Cooper-ation**	**Qualify *** **Conform ****	**Dr.'s Impression**
12/5/00 DX 7	70 in.					Poor	Yes	attempts on the pre-bronchodilator but was unable to make valid & consistent effort. Spirometry is therefore unreliable.
Dr. Ranavaya 12/5/00 DX 7 Post-Bron	61 70 in.	1.45	33.8	1.70	yes	Poor Poor	Yes Yes	Mr. Brewer was instructed repeatedly to put forth the maximum effort and was vigorously coached to give consistent effort but he failed to do so & states that this is the best he can do. Spirometry is unreliable.
Dr. Gaziano 12/5/00 DX 8		No values provided						Vents are unacceptable. Less than optimal effort, cooperation & comprehension.
Dr. Dahhan 7/17/93 DX 15	57 69 in.	3.07	66	3.66	Yes	Good Fair	No Yes	Excessive hesitation during forced expiration on spirometry. Premature termination of flow therefore did not reach a

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comp-rehension** **Cooper-ation**	**Qualify *** **Conform ****	**Dr.'s Impression**
								plateau. Invalid spirometry.
Dr. Broudy 5/27/92 DX 15	53 71 in.	3.98	154[8]	5.04	Yes		No Yes	Spirometry shows a slight restrictive defect which I believe is related to suboptimal effort. Clearly the effort on the MVV was poor. The results far exceed the minimum criteria for disability is coal workers.
Dr. Dahhan 5/16/92 DX 15	52 69 in.				Yes	Good Poor		No values given. Invalid spirometry.
Dr. Cohen 4/1/92 DX 15	52 69 in.	2.69		4.44	Yes		No Yes	Moderate airway obstruction. Order pre- and post-bronchodilator spirometry if clinically indicated. Upper airway obstruction suggested. Low FEV.5 suggests poor initial effort. Significant test to test variation questionable.

*A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

[8] The copy is faintly readable. It appears as if 154 is written in as the MVV value.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of 69.8 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.98 for a male 63 years of age.[9] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.53 or an MVV equal to or less than 79; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	**Age**	**FEV_1**	**FVC**	**MVV**
68.9	63	1.92	2.45	77
72.0	63	2.17	2.77	87
67.0	61	1.79	2.29	72
70.1	61	2.04	2.61	82
68.9	57	2.01	2.56	81
70.9	53	2.24	2.82	89
68.9	52	2.10	2.64	84

[9] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 69.8" here, his average reported height.

C. Arterial Blood Gas Studies[10]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date **Ex. #**	**Physician**	**PCO2**	**PO2**	**Qualify**	**Physician Impression**
10/28/03 EX 8	Dr. Rosenberg	36.9	81.9	No	Normal.
2/26/03 CX 2	Dr. Boustani	33.2	70	No	
2/17/01 DX 16	Dr. Dahhan	26.6	96.1	No	Mr. Brewer was unable to undergo exercise.
12/5/00 DX 10	Dr. Ranavaya	34 34.7*	80 77.3*	No No	

[10] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
7/17/93 DX 15	Dr. Dahhan	38.7 40.2*	100.2 69.4*	No No	Exercise terminated due to chest pain. Minimum hypoxia. Adequate ventilation.
5/27/92 DX 15	Dr. Broudy	38.6	82.7	No	
5/16/92 DX 15	Dr. Dahhan	38.7 30.6*	85.3 62.8*	No Yes	Exercise was terminated due to shortness of breath. At rest: adequate ventilation. Normal A-a gradient for 02. End of exercise: Hyperventilation; moderate hypoxia.

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respirator or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Arthur Frank, whose qualifications are not in the record, examined the Claimant for the Workers' Compensation Board, on April 1, 1992. Dr. Frank described the Claimant's symptoms as dyspnea on exertion, low back pain, and breathing difficulties one year in duration. Dr. Frank stated that a chest X-ray done was completely negative. He concluded that the pulmonary function study was unreliable and unusable, due to poor effort.

Based on the examination, Dr. Frank concluded that the Claimant does not have an occupational lung disease caused by his coal mine employment. He also states that the miner is physically able, from a pulmonary standpoint, to do his usual coal mine employment.

Dr. Broudy's examination report, based on his examination of the Claimant, on May 27, 1992, notes 27 years of coal mine employment. He also states that claimant never smoked. (DX 15). Dr. Broudy stated that Claimant complains of weakness in the right lower extremity, shortness of breath, coughing, daily sputum, occasional bloody sputum, frequent wheezing and central chest pain associated with tiredness or aggravation. Claimant was under no medication for his breathing trouble. Claimant stated that he experienced shortness of breath on his job when lifting and dragging roof bolts. He experiences dyspnea walking 50-75 feet on level ground and can hardly go up grade. Dr. Broudy categorized the chest X-ray as 0/1. He concluded that the profusion of opacities is not sufficient to be diagnostic of coal workers' pneumoconiosis. (DX 15).

Based on the examination, arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Broudy concluded that the Claimant does not have coal workers' pneumoconiosis. Dr. Broudy also stated that Claimant "retains the respiratory functional capacity to perform the work of an underground coal miner or to do similarly arduous manual labor." (DX 15).

Dr. Dahhan is Board-certified in internal and pulmonary medicine. Dr. Dahhan examined the claimant on May 17, 1992. He notes 22 years of coal mine employment. (DX 15). Mr. Brewer complains of daily cough, productive of clear sputum with no hemoptysis, morning wheezing, dyspnea on exertion, and occasional chest pain. Dr. Dahhan stated that the results of an arterial blood gas were normal. A spirometry was attempted, "due to hesitation and lack of forceful effort the tracings are invalid by the Department of Labor and AMA criteria." (DX 15).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Dahhan found "no evidence of occupational pneumoconiosis or pulmonary disability, secondary to coal dust exposure." (DX 15). Furthermore, "[d]ue to his poor effort when performing spirometry direct measurement of his ventilatory reserve is not possible, though he appeared to retain the respiratory capacity to continue his previous coal mining employment." (DX 15).

Dr. Dahhan again examined the Claimant on July 17, 1993. He notes 22 years of coal mine employment and that Mr. Brewer is a non-smoker. Dr. Dahhan concluded that there is "insufficient objective findings to justify the diagnosis of occupational pneumoconiosis." (DX 15). Dr. Dahhan described Claimant's symptoms as daily cough with the production of clear sputum with occasional blood streaks in it, morning wheezing, dyspnea upon exertion and occasional pain in the right chest.

Dr. Dahhan found that examination of the chest showed good air entry to both lungs. The arterial blood gases at rest showed normal values. Claimant developed chest pain after 2 minutes of exercise. He stated that Mr. Brewer has a history of chronic bronchitis with no objective finding to support that diagnosis on clinical, radiological or physiological testing. Dr. Dahhan determined that from a respiratory standpoint, Mr. Brewer retained the capacity to continue his previous coal mining work. (DX 15).

Dr. Dahhan examined the Claimant for a third time on February 17, 2001. (DX 16). Dr. Dahhan stated that Claimant's coal mine employment ended in 1991 after a fractured right facial bone. Dr. Dahhan described the claimant's symptoms as daily cough with productive clear sputum but no hemoptysis, frequent wheeze, dyspnea on exertion, and occasional chest pain.

Dr. Dahhan's report states that an examination of the chest showed good air entry to both lungs with no crepitation, rhonci or wheeze. The cardiac examination showed regular rhythm with normal heart sounds. An electrocardiogram was also taken and showed regular sinus rhythm with normal tracings. (DX 16).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Dahhan found "no evidence of occupational pneumoconiosis or pulmonary disability secondary to coal dust exposure." Dr. Dahhan concluded that Mr. Brewer "retains the respiratory capacity to continue his previous coal mining work." (DX 16).

Dr. Dahhan was deposed by Employer's Counsel on July 5, 2001. (EX 3). Dr. Dahhan stated that he examined the Claimant on three occasions: May 1992, July 1993 and February 2001. (EX 3; p. 5). Dr. Dahhan stated that Mr. Brewer has a sufficient history within which a susceptible individual could contract coal workers' pneumoconiosis. (EX 3; p. 6). He found that the lungs were clear, with no abnormal sounds. There was no crepitation, rhonchi, crackle or wheeze in the lungs. Dr. Dahhan performed pulmonary function studies and arterial blood gas studies on the Claimant at each examination. He stated there was no change in the pulmonary function studies. The arterial blood gas studies were comparable and essentially normal. Claimant would not undergo an exercise study. Dr. Dahhan stated that Claimant's back pain was the main reason for his declining the exercise study. (EX 3; p. 9-11).

Dr. Lane, whose qualifications are not in the record, reviewed the Claimant's medical records and submitted his opinion in a report, dated June 21, 1993. His consultation report notes 27 yeas of coal mine employment. In his review of the X-ray readings, Dr. Lane states that more recent X-rays have been interpreted as negative for pneumoconiosis. As such, he states "since coal workers' pneumoconiosis is a permanent disease, one would not expect clearing on subsequent X-rays." (DX 15). He further finds that the pulmonary function studies reviewed are generally invalid and the MVV maneuvers are not valid because of poor effort. The arterial blood gases reviewed are normal.

Based on the medical records, Dr. Lane found that "Mr. Brewer does have the respiratory ability to perform the work of a coal miner." (DX 15).

Dr. Anderson, whose qualifications are not in the record, submitted a consultation report, based upon his review of the medical records of the claimant, dated June 29, 1993. (DX 15). Dr. Anderson did not discuss Claimant's symptoms. Dr. Anderson reviewed six X-rays readings that were positive for pneumoconiosis and nine readings that were negative for pneumoconiosis. He also reviewed five pulmonary function studies. He found three of these studies entirely invalid and the MVV invalid on the other two studies. Dr. Anderson also stated that the arterial blood gas studies reviewed were normal.

Based on the medical records, Dr. Anderson diagnosed no impairment due to the inhalation of coal mine dust. He further concluded that Mr. Brewer has the respiratory capacity to perform the work of a coal miner.

Dr. Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader's consultation report, dated February 2, 1994, based upon his review

of the medical records of the claimant, concluded that there is "insufficient objective medical evidence to definitively diagnose simple coal workers' pneumoconiosis." (DX 15). Dr. Fino determined that the spirometry indicated no abnormality in the Claimant's lung function. Dr. Fino further stated that the drop in Claimant's PO2 is not of sufficient magnitude to prevent him from returning to his last coal mine job. The medical records show a mild impairment in oxygen transfer, however, Dr. Fino determined that such impairment is not disabling and would not prevent Mr. Brewer from returning to his last coal mining job. He also stated that the impairment in oxygen transfer in the absence of any other stigmata of pneumoconiosis would not likely be related to the inhalation of coal mine dust. (DX 15).

On August 26, 2002, Dr. Fino submitted a second consultation report, based upon his review of the medical records of the claimant. (EX 2). After his review of the most recent medical evidence, Dr. Fino found that the Claimant no longer has an oxygen transfer impairment. (EX 2). Dr. Fino found insufficient objective medical evidence to justify a diagnosis of clinical or legal pneumoconiosis. Claimant has no respiratory impairment. He stated that "from a respiratory standpoint, this man is neither partially nor totally disabled from returning to his last coal mine employment." Furthermore, Dr. Fino concluded that even if he assumed the Claimant had clinical or legal pneumoconiosis, the finding of no respiratory impairment and disability would be the same. (EX 2).

Dr. Ranavaya's qualifications are not in the record. His examination report, based upon his examination of the claimant, on December 5, 2000, notes 22 years of coal mine employment and states the claimant never smoked. (DX 9). Dr. Ranavaya described the claimant's symptoms as daily sputum, wheezing, dyspnea, cough, hemoptysis, occasional chest pain, orthopnea, occasional ankle edema, and daily paroxysmal nocturnal dyspnea. Mr. Brewer complained of shortness of breath upon mild to moderate exertion. The Claimant said he becomes short of breath when walking 50 feet on level ground, 10 feet up a gentle incline and up 3 steps. In 1991, Claimant had a work-related head injury.

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Ranavaya diagnosed no cardiopulmonary problem and, thus, no pulmonary impairment which would prevent the claimant from performing his last coal mine job. (DX 9).

Dr. Rosenberg is a B-reader and is Board-certified in internal medicine, pulmonary disease and occupational medicine. Dr. Rosenberg has had various teaching responsibilities in Internal and pulmonary medicine, in addition to an extensive list of lectures and publications on the subjects. (EX 7). His consultation report, based upon his review of the medical records of the claimant, dated August 21, 2002, notes 22 years of coal mine employment and no smoking history. (EX 1). Dr. Rosenberg stated that his lungs are clear on auscultation. Additionally, Claimant's pulmonary function tests have generally been performed with incomplete and inconsistent efforts.

Based on the medical evidence, Dr. Rosenberg diagnosed no interstitial form of coal workers' pneumoconiosis or chronic obstructive pulmonary disease. He stated that from a functional perspective, there is no restriction and no significant obstruction. Dr. Rosenberg found no disabling respiratory condition which would prevent him from performing his previous coal mining job. Dr. Rosenberg explained that the medical evidence coupled with the fact that

the "overwhelming majority of B readings have been negative for the presence of micronodular changes related to past coal dust exposure, one can appreciate that Mr. Brewer does not have the interstitial form of coal workers' pneumoconiosis." (EX 1).

Dr. Rosenberg was deposed by Employer's Counsel on October 4, 2002. (EX 4). Dr. Rosenberg stated that Mr. Brewer's 22 years of coal mine employment is a sufficient history within which a susceptible individual could contract coal workers' pneumoconiosis. (EX 4; p. 5).

Dr. Rosenberg explained his conclusion regarding Mr. Brewer's radiographic evidence:

> That there were eight X-rays in the file upon which 34 B-readings were performed. 24 of the B-readings were negative for the presence of CWP; thus, the overwhelming majority of B readings were negative for the presence of CWP, so I would consider his X-rays as being negative.

(EX 4; p. 6-7).

Dr. Rosenberg concluded that "the pulmonary function studies from a general perspective were normal." (EX 4; p. 7). Dr. Rosenberg determined that the following pulmonary function studies were incomplete: (1) Dr. Ranavaya, December 5, 2000; (2) Dr. Wright, February 2, 1992; and (3) Dr. Carrillo, December 1, 1992. Furthermore, "even though the tests over the years have demonstrated incomplete efforts, they still are exceedingly above disability criteria." (EX 4; p. 8-9). Based on the studies, Dr. Rosenberg concluded that Mr. Brewer retained the pulmonary capacity to do his prior job in the mining industry. The pulmonary function studies demonstrate that there is no disability. (EX 4; p. 12).

Dr. Rosenberg interpreted the results of the arterial blood gas studies as normal. He further stated that looking at the arterial blood gas studies in total suggests that there is a possibility of a gas exchange abnormality. (EX 4; p. 13). However, he goes on to state that a gas exchange abnormality is a permanent condition. The most recent study did not show a PO2 which fell with exercise. This is evidence that there is no gas exchange abnormality. (EX 4; p. 13).

> Dr. Rosenberg explained legal and medical pneumoconiosis:
> Q: What is legal pneumoconiosis?
> A. Legal pneumoconiosis is any form of respiratory condition which has been caused or hastened by coal mine dust exposure.
> Q: What is medical?
> A: Medical refers simply to the presence of the interstitial variety of CWP, either simple or complicated disease.
> Q: In your opinion, does this gentleman have either legal or medical pneumoconiosis?
> A: No.

(EX 4; p. 15).

On September 4, 2003, Dr. Rosenberg wrote an addendum to his August 21, 2002 medical report. (EX 6). To prepare the addendum, Dr. Rosenberg reviewed: (1) Dr. Pathak's

reading of a February 2, 2003 X-ray and (2) a pulmonary function study, dated February 26, 2003. Dr. Pathak read the X-ray as profusion of 1/2. The pulmonary function study demonstrated a FVC of 3.56 with an FEV_1 of 2.81.

Dr. Rosenberg stated that despite Dr. Pathak's positive reading, the overwhelming majority of readings have been negative for the presence of micronodular changes relating to past coal dust exposure. Furthermore, Dr. Rosenberg found that the pulmonary function study did not demonstrate restriction or obstruction. He also stated that Claimant performed with incomplete effort. (EX 6).

Dr. Rosenberg concluded that the additional medical evidence does not change his previous diagnosis that Mr. Brewer does not have coal workers' pneumoconiosis. Additionally, he found that, from a respiratory perspective, Mr. Brewer could perform his previous coal mine job or similarly arduous work. (EX 6).

Dr. Rosenberg examined the Claimant on October 28, 2003. His report, dated November 4, 2003, is based on his examination of the Claimant and his review of the claimant's medical records. Dr. Rosenberg noted 22 years of coal mine employment (EX 8). Dr. Rosenberg reported the symptoms as told to him by the Claimant. The Claimant stated that he had chest pains with breathing difficulties, and he was worse when laying down. Claimant becomes short of breath walking 30 to 40 feet or climbing up any number of steps. He also has cough productive of sputum in the mornings. Claimant must sleep sitting up with three pillows. (EX 8).

Dr. Rosenberg performed a pulmonary function study on the Claimant. This resulted in a TLC of 6.50 liters (96% of predicted) with an RV/TLC of 128% predicted. Dr. Rosenberg explained "it can be appreciated that Mr. Brewer's TLC was 96% predicted, which indicates he does not have restriction." (EX 8). In addition, his diffusing capacity indicated that the alveolar capillary bed within his lungs appears intact. Dr. Rosenberg found that "[f]rom a pulmonary perspective, Mr. Brewer has no significant obstruction or restriction with a normal diffusing capacity measurement." (EX 8).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Rosenberg found no evidence of coal workers' pneumoconiosis or associated impairment. "He clearly could perform his previous coal mining job or other similarly arduous types of work." (EX 8).

III. Hospital Records & Physician Office Notes

Mr. Brewer was admitted to The King's Daughters' Medical Center on November 9, 1991. (DX 15). He was admitted after being struck in the right cheek by a piece of steel while hanging a roof in a mine. The stated diagnosis was:

1. Comminuted right infraorbital rim, comminuted right malar bone ad anterior maxillary wall.
2. Cerebral concussion.
3. Muscular strain of right neck and shoulder.

Claimant had a positive loss of consciousness and was taken to the hospital. The Claimant had no recollection of the accident or the events immediately following. At discharge, the Claimant

was placed on sinus precautions and instructed not to blow his nose. (DX 15). An evaluation of the chest performed while Claimant was admitted states:

> PA and lateral views of the chest were obtained in the upright position. The heart is not enlarged. The lungs are clear of acute infiltrates. The pulmonary vessels, soft tissues, mediastinum, and bony thorax are within normal limits. Impression: normal chest.

(DX 15).

IV. Doctor Deposition Testimony

On May 9, 2001, a deposition of Dr. Paul S. Wheeler was taken by Employer's Counsel. (DX 27). Dr. Wheeler is a B-reader and Board-certified in radiology. Dr. Wheeler explained what must be seen on a chest radiograph to make a determination of radiographic evidence of coal workers' pneumoconiosis:

> Small, round nodules, central portion mid and upper lung zones from less than a millimeter in diameter up to a centimeter in diameter. They should be symmetrical and in the central portions. And in advanced cases, they can spill over into the lung periphery and the lower lung zones. When the nodules get larger than a centimeter, they can be called large opacities of coal workers' pneumoconiosis.

(DX 27; p. 4-5). Dr. Wheeler testified that tuberculosis, distal plamosis, sarcoidosis, metastatic cancers and eosinophilic granuloma can mimic coal workers' pneumoconiosis on a chest film. He stated that the typical silicosis coal workers' pneumoconiosis pattern is found in the central portion mid and upper lung zones. (DX 27; p. 8-9).

Dr. Wheeler testified that he reviewed four chest X-rays of Mr. Brewer dated: February 17, 2001, December 5, 2000, July 17, 1993 and January 7, 1992. He stated that the X-rays were of diagnostic quality that he could make a determination as to whether Mr. Brewer had radiographic evidence of coal workers' pneumoconiosis. (DX 27; p. 11).

Dr. Wheeler found that the February 17, 2001 X-ray was normal except for minimal tortuosity. He explained that tortuosity is twisting of the aorta. (DX 27; p. 12). Dr. Wheeler did not find radiographic evidence of coal workers' pneumoconiosis on any of the X-rays. He also stated there were no abnormalities relating to the inhalation of coal mine dust. Dr. Wheeler stated that coal workers' pneumoconiosis is a permanent disease, unless someone resects part of the lung. (DX 27; p. 14).

V. Claimant Testimony

Mr. Brewer was deposed on June 19, 2003. (EX 5). Mr. Brewer has a seventh grade education. At the time of the deposition, he was 63 years old and married to Pauline Spaulding Brewer for 40 years.

Mr. Brewer has not worked since 1991. (EX 5; p. 6). He worked for K.T.K Mining and Construction Company as a pin top operator for four years. All of Mr. Brewer's coal mine work was underground in the mines pinning top. This position required him to be in the face of the

mine. When the miners cut a section of the mine out, Mr. Brewer had to go in and put bolts across to hold up the top structure. (EX 5; p. 16).

Mr. Brewer explained that he has breathing problems at night when he lays in bed. He can breathe "pretty good" when he is up walking around. (EX 5; p. 10). He stated that he also had breathing problems when he was working at K.T.K. Mining and Construction Company. He testified:

> Q: Would you ever have to sit down and stop and take a rest while you were working?
> A: No.
> Q: Did you ever have to take a break while you were working at K.T.K. because you were short of breath?
> A: Yes, I took breaks. When you're caught up on the pinner you could take a break.
> Q: While you were at K.T.K. did you ever have to ask your boss to change your job or let you do something different because of your breathing trouble?
> A: Oh, I asked him two or three times to take me off the pin car, but he never would take me off the pin car. I tried to get to shovel ribs, shovel belts and everything, but they never would take me off the pin car.
> Q: How come you'd asked him to take you off the pin car?
> A: They was on to me because I was pinning after a miner and all of that, and it was just so hard I just couldn't hardly keep it going and stuff like that. I was having other problems on breathing and stuff.
> Q: Were you having trouble from your breathing problems doing that work?
> A: Yes, yes.

(EX 5; p. 10-11). Mr. Brewer stated he never took medication for breathing while he was working, and at the date of the deposition was not taking any medications. (EX 5; p. 19, 26). Doctors have written prescriptions for Mr. Brewer, but he was not financially capable of having the prescriptions filled. (EX 5; p. 25). Claimant was first told by a doctor that he had black lung in 1991. (EX 5; p. 21). Claimant believes that, from a breathing standpoint, he cannot work. (EX 5; p. 29).

Mr. Brewer discussed his current breathing difficulties. He stated that he gets "worn out" going up steps and can hardly make it up steps. Mr. Brewer has most of his breathing problems when he lays flat at night. He coughs early in the morning. (EX 5; p. 30). Mr. Brewer stated that he never smoked or chewed tobacco. (EX 5; p. 35).

At the September 25, 2003 hearing, Claimant testified that he has breathing problems every night. Also, he gets out of breath quickly when moving around. Claimant's breathing problems have worsened since he quit working in 1991. (TR 9). Mr. Brewer testified he is able to walk about 40 to 50 feet before becoming out of breath. (TR 10).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986); *Adams v. Director, OWCP*, 886 F.2d 818, 820 (6th Cir. 1989). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwhich Collieries [Ondecko]*, 512 U.S. 267 at 281.

Since this is the claimant's second claim for benefits, and it was filed before January 19, 2001, under the old regulations, he must initially show that there has been a material change of conditions.[11]

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of August 30, 1994, i.e., disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3rd Cir. 1995). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc.*, 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)(*en banc on recon.*), the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that a miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the

[11] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part…[i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions…
> (Emphasis added).

issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions…"

The claimant's prior application for benefits was denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled by pneumoconiosis. (DX 28-63). Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.[12]

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[13] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[14]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or

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[12] *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122, BRB No. 98-0714 BLA (Feb. 19, 1999). Lay testimony, standing alone, regarding the miner's worsened condition, since the denial of his last claim, is insufficient to establish a material change of condition under 20 C.F.R. § 725.309, absent corroborating medical evidence.

[13] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co*., 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[14] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

substantially aggravated by, dust exposure in coal mine employment."[15] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[16] 20 C.F.R. § 718.202(a)(4).

In *Abshire v. D & L Coal Co.*, 22 B.L.R. 1-203 (2002). The board reiterated that it will not follow *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000) in cases arising in the Sixth Circuit.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a

[15] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[16] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990).This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

The October 28, 2003 X-ray is the most recent X-ray in the record. I find the October 28, 2003 X-ray negative for pneumoconiosis, because one dually qualified physician and one B-reader made a negative reading. There was no positive reading of this X-ray.

I find the February 3, 2003 X-ray neither precludes nor establishes the presence of pneumoconiosis. It was read by a dually qualified physician as negative for pneumoconiosis. A B-reader physician classified the same X-ray as 1/2.

I find the February 17, 2001 X-ray as negative for pneumoconiosis. The three readings of this X-ray all found no evidence of coal workers' pneumoconiosis. In addition, I find the December 5, 2000 X-ray as negative for pneumoconiosis. It was read by two dually qualified physicians as negative for pneumoconiosis. Two B-reader physicians classified the X-ray as 1/0. Dr. Ranavaya, whose qualifications are not in the record, classified the X-ray as 0/1. In weighing the conflicting readings, I give more weight to the opinions of the dually qualified physicians.

The remaining X-rays, dated July 17, 1993, December 1, 1992, May 27, 1992, April 1, 1992 and January 7, 1992, have only been interpreted as negative for coal workers' pneumoconiosis.

Moreover, a CT scan read by a Board-certified radiologist found no evidence of coal workers' pneumoconiosis.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from

pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[17] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Dahhan, Fino and Rosenberg above Drs. Anderson, Broudy, Frank, Lane and Ranavaya.

None of the medical reports support a finding of coal workers' pneumoconiosis. The physicians are in agreement that Mr. Brewer does not have legal or medical coal workers' pneumoconiosis.

I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993). Neither the X-ray evidence nor medical reports support a finding of coal workers' pneumoconiosis. In addition, the medical evidence taken as a whole does not support a finding of coal workers' pneumoconiosis.

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).[18]

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of

[17] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

[18] Specifically, the burden of proof is met under § 718.203(c) when "competent evidence establish[es] that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP,* 11 B.L.R. 1-110, 1-112 (1987).

coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[19] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[20] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718.

With the exception of the studies performed on December 5, 2000 by Dr. Ranavaya, all of the pulmonary function studies produce a ratio greater than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Dr. Ranavaya's study technically qualifies; however, it is given little weight. Dr. Ranavaya states that Mr. Brewer made numerous attempts on the pre-bronchodilator, but was unable to make valid and consistent effort. Therefore, he concludes that the spirometry is unreliable. Likewise, Dr. Gaziano stated that the vents of the December 5, 2000 pulmonary function study are unacceptable. Thus, the pulmonary function studies do not establish total disability.

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[19] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

[20] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii).

Seven arterial blood gas studies were performed. With the exception of Dr. Dahhan's May 16, 1992 exercise study, none of these studies produced qualifying results. Dr. Dahhan's exercise study produced technically qualifying results. But, Dr. Dahhan stated that "exercise was terminated due to shortness of breath." Additionally, Dr. Dahhan concluded that Mr. Brewer has no pulmonary disability. Therefore, based on Dr. Dahhan's interpretation of the May 16, 1992 exercise arterial blood gas study, I discredit the results of that study. Thus, the Claimant did not prove total disability based on the results of arterial blood gas studies.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

As discussed above, the record includes the medical opinions of Drs. Dahhan, Fino, Rosenberg, Anderson, Broudy, Frank, Lane and Ranavaya. These physicians are in agreement that the Claimant does not have a pulmonary impairment. They agree that, from a pulmonary standpoint, Mr. Brewer would be able to perform his last coal mining work.

I find that the miner's last coal mining positions required heavy manual labor. However, based on the medical evidence, I find he is capable of performing his prior coal mine employment.

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street,* 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments." Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

The Benefits Review Board has held that nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability, under 20 C.F.R. § 718.204. *Beatty v. Danri Corp.*, 16 B.L.R. 1-1 (1991).

I find the claimant has not met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability[21]

Since I have found that the evidence of record fails to establish that Mr. Brewer has (clinical or legal) pneumoconiosis and that he suffers from no total respiratory disability, I accordingly find that Mr. Brewer failed to establish that he suffers from a total respiratory disability due to clinical or legal pneumoconiosis.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has not established that a material change in condition has taken place since the previous denial. The claimant does not have pneumoconiosis, as defined by the Act and Regulations. The claimant is not totally disabled. Thus, he is not totally disabled due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER

It is ordered that the claim of JACK BREWER for benefits under the Black Lung Benefits Act is hereby DENIED.

A

RICHARD A. MORGAN
Administrative Law Judge

[21] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. __, BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**

APPENDIX A

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 8	10/28/03 10/28/03	Dr. Rosenberg	B	1		No parenchymal abnormalities consistent with pneumoconiosis.
EX 8; 10	10/28/03 10/28/03	Dr. Poulos	B, BCR	1		Lung fields are well expanded and clear. No nodular opacities are seen to suggest the presence of coal workers' pneumoconiosis. Left 5th rib- old healed fracture. No evidence of pneumoconiosis.
EX 12	2/3/03 10/13/03	Dr. Wiot	B, BCR	1		No evidence of coal workers' pneumoconiosis. There is aortic ectasia. The chest is otherwise unremarkable.
CX 1	2/3/03 2/6/03	Dr. Pathak	B	2 – bilateral scapula overlay	1/2	Minute soft rounded parenchymal densities measuring up to 3 mm are seen throughout both lungs. No evidence of localized pneumonia. Slight thickening of the minor fissure. Simple pneumoconiosis.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 22	2/17/01 3/14/01	Dr. Scott	B, BCR	2 - Underexposure		No evidence of coal workers' pneumoconiosis. Healed fracture left 5th rib.
DX 22	2/17/01 3/13/01	Dr. Wheeler	B, BCR	2 - Underexposure		Normal except minimal tortuosity descending thoracic aorta and subtle healed fracture left rib – 5. CTR: 15/32. Light film accentuates pulmonary vessels but there is no evidence of silicosis or coal workers' pneumoconiosis.
DX 16	2/17/01 2/17/01	Dr. Dahhan[22]	BCI(P)	1		No coal workers' pneumoconiosis. Chest X-ray showed borderline heart size. Otherwise, the lung fields are clear with no pleural or parenchymal abnormalities consistent with pneumoconiosis being present. ILO classification is 0/0.

[22] I take judicial notice of the NIOSH B-reader list found on the OALJ website. This list states the following reader certifications for Dr. Dahhan:

August 1, 1987 – July 31, 1991: B Reader
August 1, 1991 – November 30, 1995: A Reader
December 12, 1995 - November 30, 1999: B Reader

The CDC website lists Dr. Dahhan as a current B Reader. There is no information regarding whether Dr. Dahhan was a B Reader in 2001.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 26	12/5/00 5/1/01	Dr. Scott	B, BCR	2 – Slight underexposure		No Coal workers' pneumoconiosis. Minimal anterior wedging few t-spine vertebrae. Healed fracture left 5th rib.
DX 26	12/5/00 5/1/01	Dr. Wheeler	B, BCR	2 – minimal underexposure		No coal workers' pneumoconiosis. Normal except healed left rib fracture and anterior weding few vertebrae mid T-spine and minimal tortuosity descending thoracic aorta.
DX 11	12/5/00 2/14/01	Dr. Gaziano	B	1	1/0	
DX 12	12/5/00 1/20/01	Dr. Navani	B	2	1/0	
DX 13	12/5/00 12/5/00	Dr. Ranavaya		1	0/1	
DX 15	7/17/93 8/16/93	Dr. Kim	B, BCR	1		Completely negative.
DX 15	7/17/93 8/12/93	Dr. Eisner	B, BCR	2 – scapular overlap		Completely negative. Top normal heart size.
DX 15	7/17/93 8/3/93	Dr. Scott	B, BCR	1		Completely negative for pneumoconiosis. Top normal heart size.
DX 15	7/17/93 8/3/93	Dr. Wheeler	B, BCR	1		Completely negative. Top normal left ventricle with CTR: 15/30. Check for hypertension. No other abnormality.
DX	7/17/93	Dr.	A, BCI(P)	1		Completely

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
15	7/18/93	Dahhan				negative.
DX 15	12/1/92 6/30/93	Dr. Scott	B, BCR	1		Top normal heart size. - ? Hypertension. No evidence of silicosis or coal workers' pneumoconiosis.
DX 15	12/1/92 6/30/93	Dr. Wheeler	B, BCR	1		Top normal left ventricle with CTR: 15/30. Check for hypertension. Decreased lung markings in apices and portion upper lobes compatible with possible emphysema/suggest clinical correlation. Slight anterior wedging one mid thoracic vertebra compatible with healed trauma and no other abnormality. No evidence of silicosis or coal workers pneumoconiosis.
DX 15	12/1/92 4/9/93	Dr. Wiot	B, BCR	2		Completely negative.
DX 15	12/1/92 4/8/93	Dr. Spitz	B, BCR	1		Completely negative.
DX 15	5/27/92 5/27/92	Dr. Broudy		1	0/1	
DX 15	5/16/92 7/27/92	Dr. Poulos	B, BCR	1		Completely negative.
DX 15	5/16/92 5/17/92	Dr. Dahhan	A, BCI(P)			Completely negative.
DX 15	4/1/92 4/2/92	Dr. Lieber	B, BCR	2		Completely negative.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 15	1/7/92 2/3/94	Dr. Scott	B, BCR	1		Completely negative. Top normal heart size with no evidence of silicosis or coal workers' pneumoconiosis.
DX 15	1/7/92 2/3/94	Dr. Wheeler	B, BCR	2 – Slight underexposure		Completely negative for coal workers' pneumoconiosis. Normal with CTR: 15/30.5.
DX 15	1/7/92 8/13/93	Dr. Spitz	B, BCR	1		Completely negative. No evidence of coal workers' pneumoconiosis.
DX 15	1/7/92 8/13/93	Dr. Wiot	B, BCR	1		Completely negative. No evidence of coal workers' pneumoconiosis. The chest is within normal limits.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.